STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		
AND I LAN OF CONNECTION			A. BUILDING:		COMPLETED	
		IL6014120	B. WING		C 11/18/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ILLINOIS	VETERANS HOME - ANN	792 NOR				
(V4) ID	SLIMMARY ST	ANNA, IL		PROVIDER'S PLAN OF CORRECTION	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S 000	5 000 Initial Comments		S 000			
	Complaint # 1556259/IL81507					
STATEMENT OF LICENSURE VIOLATIONS:						
S1505	O5 Section 340.1505 Medical, Nursing and Restorative Services		S1505			
	~	ot met as evidenced by: 5) Medical Nursing and				
	and services to attain maintain the highest pand psychosocial well of the resident, in acc resident's compreher plan. Adequate and p care shall be provided	practicable physical, mental, ll-being cordance with each				
	transfer activities as r	nel shall assist and with ambulation and safe necessary in an effort to help iin their highest practicable				
	This requirement is n	ot met as evidenced by :				
		ailed to provide a ely support the weight of 1 of e sample of 3 reviewed for				
	Findings include:					
	R2's Admission MDS	(Minimum Data Set) dated				

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDE		IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED	
IL6014120		B. WING		C 11/18/2015		
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
II I INOIS	VETERANS HOME - ANN	792 NORT	H MAIN			
ILLIIVOIO	VETERANO HOME - ANI	ANNA, IL	62906			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
\$1505	6/28/2014 states that Morbid Obesity and v 423 pounds and uses mobility. This same of Section Q0300 Reside that R2 "expects to r MDS of 9/22/2015 also to remain in the facilitinate. This same doccontinues to use a whombility and requires. On 11/17/2015 at 3:1 Nursing, stated that F 10/14/ 2015 from a homolity and requires. On 11/17/2015 at 3:1 Nursing, stated that F 10/14/ 2015 from a homolity and requires. On 11/17/2015 at 3:1 Nursing, stated that F 10/14/ 2015 from a homolity and requires. In the facility and requires assisted to the bathroform the toilet. E2 fur sit-to-stand mechanic was realized at that the weight of 475 pounds capacity of 440 pound in the facility. E2 state eventually able to get at this time. E2 state assistance using such the facility began acting sit-to-stand on this dam, E2 stated that proceed that proceed that proceed the facility of the sudden, and that E2 incidents or report of of his wheelchair price October and that Reswith R2 also. E2 added to the facility on 11/15	R2's diagnoses include was admitted with a weight of a walker and wheelchair for document indicates in lent 's Overall Expectation emain in this facility." R2 's so indicates that R2 expects by and that R2 is cognitively rument indicates that R2 neelchair and walker for supervision for transfers. 5 pm, E2, Director of R2 returned to the facility on obspital stay and was soom and was unable to rise ther stated that using a real lift was considered and it me that R2 's last recorded a exceeded the weight do of all the mechanical lifts and further that R2 was a up and the lift was not used do that R2 had never required in a device before, but that vely searching for a bariatric rate. On 11/18/2015 at 9:15 for to 2 hospitalizations in sferring with stand-by assist alker with the Physical at his loss of strength was was not aware of any R2 not being able to get out r to his hospitalizations in storative staff was working and that a company is coming R2015 to demonstrate a sift that can be purchased	\$1505			

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STATE FORM SU0T11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILBING.			0	
IL6014120		B. WING			C 11/18/2015		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	VETERANG HOME AND	792 NOR	RTH MAIN				
ILLINOIS	VETERANS HOME - ANN	NA ANNA, II	_ 62906				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	(X5) COMPLETE DATE		
\$1505	A Nurse 's Progress entered at 17:09 state to the facility from a harmonic Nurse's Note for R2 of s post hospital weigh On 11/18/15 at 9:15 at 11/09/2015 E2 received stating that "R2 was weak to stand from have any other option sit-to-stand, he was reweight restrictions of this was the safest are stated that "this was 10/30/2015 that R2 hand that E10, Registe use the device for R2 on 11/18/2015 at 10: sit-to-stand had been sure of the date, but after return from hospiand probably in the firstated that R2 was be said he couldn't stan weak and that the an	Note dated 10/29/2015 and es that R2 was re-admitted hospital around 15:30 pm. A dated 10/30/2015 states R2 't is now 458.5 pounds. Image: Example of the transfer of the tra	S1505				
	move to a sitting positrapeze and quarter but with walker, and then	5 am R2 was observed to ition in bed with use of a ped rail, stand at bedside back himself into his d-by assist from staff. On					
	stand had to be used from his second hosp 10/29/2015.) R2 furth were to assist him to	R2 stated that the sit-to twice since he returned bitalization in October (her stated that both incidents get up from wheelchair.					

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STATE FORM SU0T11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
	A. BUILDING:							
IL6014120		B. WING		C 11/18/2015				
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
I ILLINOIS VETERANS HOME - ANNA								
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE		
\$1505	T92 NORTH ANNA, IL 6 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S1505					

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